Case Summary:
This is a challenging case of fifty years old gentleman presented by STEMI (LBBB), cardiogenic shock then he developed cardiac arrest. PCI was done post CPR and under mechanical ventilation, IABP, temporary pacemaker and Extracorporeal Membrane Oxygenation (ECMO) support. Coronary angiogram revealed subtotal occlusion of the three coronary arteries. PCI was performed to proximal to distal LAD (culprit lesion) using three bare-metal stents (BMS) (Integrity 2.75x30, 3x30 and 3x18 mm) with Guideliner support, to LCX subtotal occlusion using one BMS (Integrity 2.75x22 mm) and to RCA subtotal occlusion using three BMS (Integrity 3.5x12mm, 3.0x30 and 3x30 mm). Patient was discharged in good medical condition after one month.

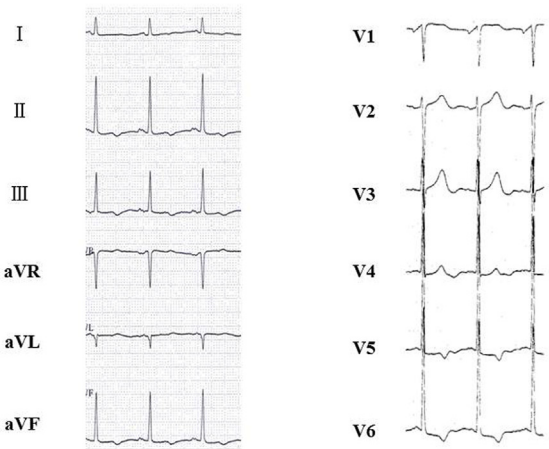
TCTAP C-151

Percutaneous Coronary Intervention for Bilateral Coronary Ostial Stenosis with Aortitis

Kou Hoshino
Tokyo Medical University, Japan

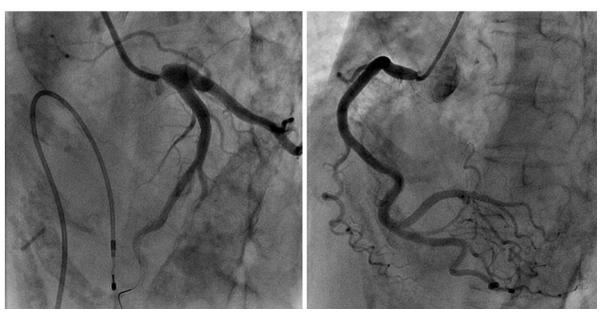
[Clinical Information]
Patient initials or identifier number:
T.K
ID: 12454015
Relevant clinical history and physical exam:
A female in 70s who was treated for 40 years as a diagnosis of the aortitis syndrome was hospitalized with congestive heart failure. Coronary angio graphy showed high grade stenotic lesions with severe calcification of bilateral coronary ostium. Furthermore, there were severe stenosis of the left subclavian artery, and total obstruction at the high level of abdominal aorta. Previously we performed angioplasty to the left subclavian artery and axillo-frmoral bypass. This time, she admitted on emergency because of unstable angina and congestive heart failure. Therefore we decided to perform percutaneous coronary intervention for bilateral coronary ostial stenotic lesions.
Relevant test results prior to catheterization:
The ECG showed a decrease of the ST segment in II, III, aVF, V5, V6.
And we could see pulmonary congestion and effusion image in the chest roentgenogram.

Electrocardiogram



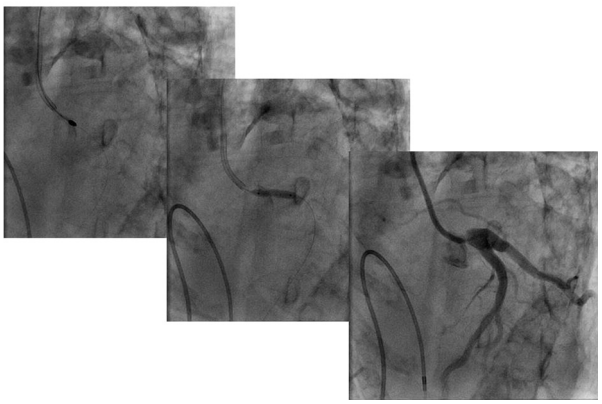
Relevant catheterization findings:
CAG revealed severe stenotic lesions with severe calcification at the bilateral coronary ostium.

CAG

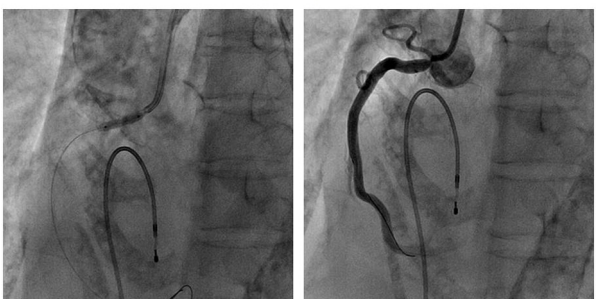


[Interventional Management]
Procedural step:
At first, we treated the LMT lesion.
After the observation of the lesion by IVUS and the evaluation by FFR, we performed rotational coronary atherectomy(Rota)using the burr of 2mm in diameter and plain old balloon angioplasty (POBA) using the balloon of the 4mm diameter.
And then, we performed POBA to RCA using the balloon of the 4mm diameter.

PCI



PCI



Case Summary:
Guiding Catheter: 7Fr JL3.5, 7FrJR4.0
Wire: BMW universal 2, Rota floppy wire
Kind of balloon catheter: KUNAI 3.0/15mm, NC Quantum 4.0/15mm
Rota burr: 2.0mm in diameter

TCTAP C-152

Stent Migration After Using Cutting Balloon

Shozo Ishihara
Mimihara Generel Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
K.O
Relevant clinical history and physical exam:
A 68-year-old woman underwent percutaneous coronary intervention (PCI) for severe stenosis in right coronary artery (RCA) osmium.Her past history was CRF on HD, inferior OMI, and Severe PAD with foot amputation.
Relevant test results prior to catheterization:
She had renal failure on hemodialysis. She also had a past history of inferior MI (#4PD occlusion) 2 weeks before, and POBA was performed.
UCG showed hypokinesis of inferior wall.
Coronary Risk Factor: HT(+) HL(+) DM(-) smoking(-) HD(+)
Relevant catheterization findings:
CAG showed severe calcified lesion at RCA ostium and mid RCA.
[Interventional Management]
Procedural step:
Heavy calcified lesion was not expanded enough by 3.75mm low compliant balloon dilatation, so we performed additional dilatation by 3.5mm cutting balloon. After that, we inserted a Biolimus eluting stent (BES) and started to inflate. Subsequently, we noticed the contrast leakage and the occurrence of balloon rupture. Immediately, we deflated the balloon and tried to retrieve the stent and delivery system. But we could not pull the system into the guiding catheter because the proximal side of the stent was already half-expanded, and the stent was striped from the delivery system during the procedure. We tried to retrieve it using a loop snare, a small profile balloon catheter and a large size guiding catheter, but could not. Unwillingly, we decided to implant the stent into brachial artery and implanted a new stent into RCA ostium.